Exhibit "D"

TURN KEY HEALTH

DATE: _____ **DLM #:** _____

INMATE NAME: _____ **DOB #:** _____

TESTING & CONTACT HISTORY

1. HAVE YOU BEEN TESTED FOR THE CORONAVIRUS/ COVID-19? YES ☐ NO ☐
   IF YES: WHEN: _____ WHERE: _____
2. HAVE YOU BEEN QUARANTINED IN THE LAST MONTH? YES ☐ NO ☐
3. HAVE YOU BEEN IN CLOSE CONTACT WITH ANYONE SUSPECTED OF HAVING OR HAS BEEN TESTED FOR COVID-19? YES ☐ NO ☐

TRAVEL HISTORY

1. HAVE YOU TRAVELED OUTSIDE OF THE COUNTRY IN THE LAST 2 WEEKS? YES ☐ NO ☐
   a. IF SO: WHEN: _____ WHERE: _____
2. HAVE YOU TRAVELED BY PLANE IN THE LAST MONTH?
   a. IF SO: WHEN: _____ WHERE: _____
3. HAVE YOU BEEN IN A GROUP OF 10 OR MORE PEOPLE IN THE LAST 2 WEEKS? YES ☐ NO ☐
4. HAVE YOU BEEN OUTSIDE OF THE STATE OF OKLAHOMA IN THE LAST 2 WEEKS? YES ☐ NO ☐
   a. IF SO: WHEN: _____ WHERE: _____

HEALTH HISTORY

1. DO YOU HAVE ANY CHRONIC MEDICAL CONDITIONS? YES ☐ NO ☐
   a. IF SO: WHAT? _____
   _____
2. IN THE LAST 14 DAYS HAVE YOU HAD ANY OF THE FOLLOWING:
   a. FEVER YES ☐ NO ☐
   b. COLD OR FLU LIKE SYMPTOMS YES ☐ NO ☐
   c. COUGH YES ☐ NO ☐
   d. SHORTNESS OF BREATH YES ☐ NO ☐

_____ _____

DETENTION STAFF SIGNATURE MEDICAL STAFF SIGNATURE

TO BE FILLED OUT BY MEDICAL STAFF:

TEMP: _____ Respirations: _____

BP: _____ Shortness of Breath: ____ Y ____ N

02Sat: _____ Cough: ____ Y ____ N If yes, productive cough: ___ Y ___ N

RECOMMENDATION:

NOT FIT FOR JAIL (REQUIRES PROVIDER VERBAL ORDER ☐ CLEARED FOR INTAKE POD ☐

NEGATIVE PRESSURE CELL (REQUIRES PROVIDER ORDER) ☐ QUARANTINE POD (IF AVAILABLE) ☐